A brief moment of glory: the impact of the therapeutic community movement on the drug treatment systems in the UK

Rowdy Yates

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Correspondence to:

Rowdy Yates
Scotttish Addiction Studies

Department of Applied Social Science

University of Stirling

Stirling FK9 4LA

Tel: 01786 – 467737

e-mail: p.r.yates@stir.ac.uk

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Abstract

The introduction of concept-based therapeutic communities, based upon the model pioneered by Charles Dederich with the Synanon community in California, was a significant development in the evolution of drug treatment provision in the UK. For a short period in the 1970s, these communities enjoyed unparalleled influence in the development and direction of treatment approaches across the whole spectrum of services.

This paper considers the developments in psychiatry and social care that prepared the ground for that phenomenon. In addition, the paper considers the subsequent demise in the importance of therapeutic communities to the direction of drug policy and the implications that this might have for future development of residential treatment services.

Introduction

To understand the extraordinary impact concept-based therapeutic communities have had upon other United Kingdom drug treatment modalities, it is important to understand not only the general mood and nature of those other services at the time of their transposition, but also the changes which had been seen in the treatment of the mentally ill and the socially dislocated over the previous decades.

Whilst this paper focuses on the experience in the United Kingdom during the first decades after the importation of the concept-based idea from the United States, there is some evidence (Kooyman, 1993, Kooyman, 2001) that the rise and subsequent decline in influence of this type of treatment was mirrored, at least in part, throughout Europe.

A great deal of energy has been expended upon the scientific search for the predecessors of the Synanon experiment (Bassin, 1978; Broekaert, Bracke, Calle, Cogo, Van Der Straten & Bradt,

1996; Kooyman, 1993). However, of more immediate interest to the sociologist, is the remarkable ease with which a quintessentially American approach to treatment and rehabilitation was integrated into the UK drug treatment system.

In part, of course, the answer lies in the British view of addiction and drug use at that time. Since the focus of British drug policy (and, consequently the British drug treatment system) was firmly upon heroin and cocaine, to the almost total exclusion of the more universally popular amphetamines (Spear, 1994; Yates, 1999); and since these drugs, with their associations with jazz music and Hollywood films, were seen as products of a wayward USA, it was perhaps, unsurprising that post-war Britain viewed drug addiction as an American disease which would, presumably, respond to American treatment regimes.

However, this reframing of the drugs experience as the 'fault' of the outsider, the stranger, the foreigner, is common to most cultures (Inglis, 1975) and goes only part of the way to explaining a phenomenon whose legacy within the UK drug field remains clearly discernable over thirty years later.

A fertile environment

The groundbreaking work of Maxwell Jones, Tom Main and others, in the development of so-called 'democratic' therapeutic communities, first at Hollymoor Hospital, Northfield and later at the Henderson Hospital, have often been described (Broekaert et al, 1996; Kennard, 1983; Kooyman, 2001). However, with one or two exceptions, at least in the UK, these experiments were kept within the broad tradition of in-patient psychiatric treatment and were largely unknown outside psychiatry.

Nevertheless, these developments were significant elements of broader changes within psychiatric treatment as a whole. For the previous century, psychiatry had been little more than a specialist

branch of the criminal justice system, with psychiatrists providing incarceration and basic remedial treatment for the insane (Berridge, 1999). The impact of the work of Freud, Jung, Klein and others coupled with the availability of new and powerful drugs had led to dramatic changes in post-war psychiatry. Whilst some of these changes were purely about the use of psychoactive drug treatments to facilitate a more humane management of mental illness, others focused upon the 'talking therapies' pioneered by Freud et al, whilst still others, such as the experiments with LSD and psychodrama at Powick Hospital (Sandison, 1997) were a conscious attempt to marry the two emergent traditions.

Foremost amongst this new radical group of doctors and therapists was the Scottish psychiatrist, R. D. Laing. Laing had already been acclaimed for his experimental work in Scotland with the establishment of his 'rumpus room' in a Glasgow hospital, when in the 1960s, he took the extraordinary step of moving his patients out of the psychiatric hospital altogether and establishing them in an anarchic therapeutic community – Kingsley Hall – in the east end of London (Cooper, 1967; Laing, 1965; Laing, 1994). Laing, and other members of the Phildelphia Association he established, both influenced and in turn, were influenced by, patient-led movements such as People not Psychiatry (PNP) and the emergent Italian movement, Psychiatrica Democratica (Basaglia, 1988; Wilkinson & Cox 1986). These were movements that brought together mental health patients, radical health workers and social and political activists in a common cause to promote 'community healing' outside the established, hospital-based psychiatric traditions.

Meanwhile, parallel experiments in the treatment of 'maladjusted' or 'wayward' children and young people had been quietly proceeding for the past century or more. The movement towards the establishment of self-help communities for socially dislocated young people began in Europe with the work of juvenile justice reformers such as August Aichorn (Mohr, 1966) and educationalists

such as Steiner, Pestalozzi and Montesori. In the UK, the genesis of the movement is usually credited to an American former woodwork teacher called Homer Lane.

Lane was a charismatic free-thinker who had led the self-governing Boys Republic in the USA. Impressed by Lane's approach to working with the most aggressive and delinquent children, George Montagu (later Lord Sandwich) invited him to the UK where he established the Little Commonwealth. The Little Commonwealth, on Montagu's 200-acre estate, accepted 'unmanageable' children both from the courts and from their parents. Lane's approach was a mixture of tough love (including some corporal punishment), extensive self-government and hard manual labour. Residents were divided into self-regulating 'families' and paid a wage for their work. This wage was pooled and used to clothe and feed the family. Those who idled - and thus reduced the family's income - were forcefully reprimanded by their peers in family meetings (Bridgeland, 1971).

The experiment, however, founded as it was largely on the charismatic presence of Lane himself, was ultimately doomed. In 1917, the Home Office withdrew support following unsubstantiated allegations against him of sexual impropriety by two female residents (Lane had become fascinated by the work of Freud and Jung and had embarked on a programme of rather amateurish psychoanalytic sessions with some of the children) and Lane, accused on a technical charge of failing to register as an alien, agreed to go into voluntary exile. Without Lane, the Little Commonwealth collapsed within a year and, upon his death in Paris in 1925, W. H. Auden (1937) wrote:

> Lawrence was brought down by the slut hounds
> Blake went dotty as he sang
> Homer Lane was killed in action
> By the Twickenham Baptist gang.

The legacy of Lane's Little Commonwealth was an impressive one, inspiring the work of the radical educationists, A. S. Neil and J. H. Simpson. Neil claims that such was Lane's influence on him, that he felt himself incapable of independent thought until Lane's death broke the spell (Bridgeland, 1971).

Of all the inheritors of the Little Commonwealth innovations, the most important was perhaps David Wills. Wills, a former Borstal housemaster, was employed by the Q Camps Committee (later to evolve into the Planned Environment Therapy Trust) to manage a new experiment with delinquent youths called the Hawkspur Experiment. Wills, who freely acknowledged his debt, drew heavily upon the work of Lane. The Hawkspur Camp was founded in 1936 with staff and residents living in tents and building their own accommodation. Much of the ethos of the camp was draw from the open-air school movement but the tough love regime and the self-governing economy were pure Lane (Wills, 1967).

The personal connections of those who carried forward this work are also intriguing. Norman Glaister, who was at the time working at the Tavistock alongside Harold Bridger (a former member of the Northfield team and a central figure in the development of therapeutic communities in Italy in the 1970s), was an influential member of the Q-Camp Committee. Both Bridger and Glaister were in contact with Bertram Mandlebrote, another of Maxwell Jones' TC collaborators who went on to establish a Synanon-style TC in Oxford.

For historians of the Synanon-inspired therapeutic community movement, the story of Lane's work and his subsequent legacy evoke eerie echoes of the Dederich story and Bridgeland's often moving account (1971) of life at the Little Commonwealth leaves little doubt that this was a social experiment arising out of the same humanistic tradition.

This is not to say that Dederich was in any way influenced by Lane's work in the creation of Synanon. Rather it is to emphasise that the new therapeutic communities when they began to be established in the UK in the early 1970s were for many, both within psychiatry and the juvenile justice system, reminiscent of earlier innovations; and the more welcome for that connection.

In 1968, Dr. Ian Christie, returning from a visit to New York, converted a ward of St. James' Hospital, Portsmouth (the Pink Villa Huts, later to be renamed Alpha House) into the UK and Europe's first concept-based or Synanon-style therapeutic community. Within a few years, Professor Griffith Edwards of the Maudsley Hospital Addiction Unit had established the Featherstone Lodge Project (later Phoenix House) in south London. Around this time also, Dr. Betram Mandlebrote (see above) created a concept-based TC in Littlemore Hospital, Oxford; later, like Christie, moving his creation out of the hospital and into the wider community. Later in the 1970s, Dr. Walter Lyons, enthused by his experiences at Odyssey House, New York, began a community called Inward House in Lancaster in the north of England.

Significantly, all of these developments were, at least in part, the result of the enthusiasm of a group of progressive psychiatrists, most of whom had been charged with the running of a hospital based 'drug dependency unit' and were inspired by their contact with American TCs (notably, Phoenix House and Daytop Village) to do something quite different.

Drug Dependency Units had been established throughout the UK as a result of the report of the Interdepartmental Committee on Drug Dependence (normally called the 'Brain Committee' after its Chairman, Lord Brain). This report noted that a significant blackmarket in heroin (and to a lesser extent, cocaine) had been caused by the injudicious prescribing of a small number of London-based family doctors and proposed that the power to prescribe these drugs for the treatment of addiction

be removed from family doctors and vested in a small number of licensed medical practitioners; mainly psychiatrists working in newly established specialised units (Micheson, 1994).

The idea was that the blackmarket could be stifled by ensuring that existing users received a legal supply of drugs, sufficient to their needs, but not enough to create a surplus with which to encourage the enrollment of new recruits. But these developments took place during a period of great upheaval in psychiatry and few psychiatrists were interested in merely providing prescriptions for disaffected young people who could hardly be classified as mentally ill in the true sense of the term. The search for a solution to the drug problem appeared to lie outside the walls of the psychiatric hospital and many psychiatrists charged with the responsibility for the provision of a specialist drug service established community-based facilities.

By the late 1970s, concept based therapeutic communities accounted for almost half of the 250 residential rehabilitation beds in the UK (Yates, 1981). Whilst this is an impressive 'territorial' claim, in terms of numbers of drug users presenting for treatment, TCs were a very small player. However, their influence was felt throughout the treatment field.

By the mid 1970s, medical staff working in specialist centres were beginning to incorporate some of the techniques of the TCs into the clinical setting. The aim was to provide a more therapeutic regime than the sterile interaction that had developed; largely dominated by staff-patient manipulation around the dosage and type of substitute prescription (Mitcheson, 1994).

Non-residential treatment services, too were influenced by the TCs, with some developing pre-entry 'induction' programmes (Strang & Yates, 1982; Yates, 1979) whilst others began to undertake group work modelled upon that found in TCs. In the Netherlands, a non-residential TC was

established, and in a number of European countries, existing non-residential services restyled themselves as providers of 'non-residential rehabilitation'.

Similarly, residential services were keen to adopt some of the TC practices, and a number of Christian-based houses began to develop a more hard-edged, confrontative approach to the interactions between residents and staff (Wilson, 1978).

A sphere of influence far greater than their size

The concept-based therapeutic communities had an extraordinary impact upon treatment practices and beliefs in the UK and one that far outweighed their relative input in terms of actual client contact. There appear to be a number of reasons for this.

Firstly, the majority of other services were working with what would now be classified by Prochaska and DiClimente (1998) as 'pre-contemplative' and there can be little doubt that this is a very unrewarding client group. Other services might work with a reluctant client for many years only to see the credit for his 'cure' given to a therapeutic community to which he had been referred by the very agency whose contribution he was now apparently dismissing.

Secondly, the funding of residential treatment in the UK resulted in TC staff often working in more attractive environments (and indeed, many TCs were established in attractive large houses in rural settings). By contrast, most street agencies and drug dependency units were in unattractive areas and generally under-resourced materially.

Thirdly, whilst Freud et al had popularised the 'talking therapies' within psychiatry, radical and anti-psychiatry had placed the new tools into the hands of the lay practitioner and TC staff were at the forefront of this new movement.

Fourthly, TCs were essentially an evangelistic movement. Those within the movement saw it as an intrinsic part of their role to 'spread the word'.

Fifthly, like any emergent movement, they were also quite self-protective. They developed an exclusive fellowship of TCs of which the European Federation of Therapeutic Communities (EFTC) was a logical outcome and where regular 'jamborees' and 'joint marathons' were a natural expression of fraternity. As a result, the TCs were a strong united force within a field that was normally noted for its disunity.

Lastly, TCs not only appeared to work but they did so with aplomb. Not only did clients appear to change for the better, but also the change was often visible and dramatic. Like small children watching a conjuror, the rest of the field was often transfixed, gaping in wonderment at the magic of it. For us, the circus had come to town and some of us just wanted to run away with it!

And then it was gone

The flowering of the UK concept-based therapeutic communities lasted for a little over a decade. The waning of their influence in the 1980s was reflected in similar changes across Europe and for broadly similar reasons.

Firstly, TCs were slow to adapt to the changing demography. As the number of drug users began to spiral at the end of the 1970s (Yates, 1992) the proportion of those whose character-disordered behaviour required the sort of treatment TCs were designed to provide, began to decline. With the escalation in drug users came an escalation in drug treatment services and TCs struggled to make their voice heard in what was now a substantial treatment field dominated by community-based services. When the British Government in 1983, embarked upon a major central government-

funded pump priming initiative to establish a national network of drug treatment services, residential rehabilitation services were unable to secure more than 10% of the new money, with the lion's share (56.2%) going to community services (MacGregor, 1994).

Secondly, increasing alarm at the spread of HIV/AIDS ensured that after less than a decade in the wings, medicine had returned to centre stage. Almost overnight, the priority client changed from the drug user who wanted to stop using to the one who did not and who therefore presented the greatest risk for the spread of the virus. Effectively, the new political imperative was now infection control and TCs – the arch proponents of individual and group therapy found themselves on the margins of the debate without making any conscious movement.

Thirdly, in an increasingly finance-led culture, with a firm and progressively more ruthless squeeze on public expenditure, TCs were far too easy to cost. By comparison, community based treatments are financially dispersed with some direct costs attributable to specialist service provision but the majority spread across unemployment and housing benefit; criminal justice services; child welfare; victim support etc. Residential services rapidly gained a reputation (not founded upon any scientific evidence) for high cost provision.

Fourthly, changes in the UK public funding of care resulted in a reallocation of resources to local authorities. This left TCs – which in the UK had traditionally served a geographically diverse population – negotiating per-capita funding with a large number of local authorities who were only too aware that the purse was limited and that other, more ‘worthy’ causes needed to be funded from within the same allocation. This problem was further compounded by the growth of a private sector specialising in Minnesota Model style short treatment interventions.

As a result, most TCs in the UK found themselves under pressure to shorten programme lengths, abandon practices with which some funders were uncomfortable and ensure a higher ration of 'professional' staff. Ironically, as the UK TC movement began to accommodate changes for reasons of survival, they began to lose those distinctive elements that made them a valued contributor to the treatment panoply.

Conclusion

Perhaps it is inevitable that a development which was initially so dramatic should, in the course of time settle back into mundanity, but cold logic of this type is hardly likely to prevent those of us who were there from mourning its passing.

Clearly, the future for the TC now lies in niche marketing of a kind already beginning to be apparent in some areas. In order to ensure continued existence and integrity, TCs will in the future, need to target those areas where they can make the most impact and achieve the most good. This means designing specialised TCs for particular (vulnerable) populations such as the homeless and the dual diagnosed and establishing TCs in areas where they are likely to attract a higher proportion of their traditional client group; TCs in prisons, detention centres etc.

Certainly, establishing TCs to work in collaboration with the criminal justice system is effectively a return to earlier times since Synanon accepted court referrals from an early stage in its existence (Rawlings & Yates, 2001). It would also have the advantage of responding to the current preoccupation of most European governments with the drugs-crime axis. For, in the past decade, the political imperative has shifted once again, away from public health and towards crime prevention (Stimson, 1999).

Both Winick (1962) and Robins and Murphy (1967) have identified a natural maturing out of addiction in early middle age. It seems inevitable that the current policy of long-term prescribing will delay the onset of this phenomenon in many individuals. But it is surely unlikely that it can undermine this natural process completely. The next decade, therefore, may be marked by an increase of those on long-term prescriptions seeking detoxification and associated rehabilitative inputs. It is vital that those sectors of the treatment field best able to provide such inputs be protected, nurtured and learned from. Whatever their faults, concept based therapeutic communities have shown over the past four decades that they are able to work effectively and compassionately with those who wish to change. They have proved their worth in a world that has often been hostile to their ideals and aspirations and they have shown that they can survive and change whilst maintaining the core values which underpinned those early days in a Santa Monica waterfront hotel.

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